Data Elements sorted by Category

2.00 Record Descriptors

CHART_FAC_CD	Chart Facility Code	Code to designate the facility where this chart is located. See standard code table.
CHART_NBR	Chart Number	A patient's health record number (HRN) at the specified facility.
CHART_STATUS_CD	Chart Status Code	Status of the specified chart at the local facility. ('A' = Active, 'I' = Inactive, 'D' = Deleted.)
DATA_1ST_ENTRY_DC	Data Entry Creation Date (character format)	Date data entry first "touched" the visit. Character field formatted as CCYYMMDD.
DATA_1ST_ENTRY_DT	Data Entry Creation Date (date format)	Date data entry first "touched" the visit. Will be available prospectively only. Date field.
DATE_LAST_MOD_TS	Date of Last Update	Date last modified by the local registration/encounter system.
ENCTR_DEL_FG	Encounter Delete Flag	Flag received from the local system that indicates that this encounter was deleted from the local system.
ENCTR_EXPORT_TS	Encounter Export Date	Date this "snapshot" of the local encounter record was exported.
EXPORT_BOX_ASUFAC	Static ASUFAC of Exporting Box	Code used to identify the actual machine from where the data originated.
EXPORT_LOG_NBR	Export Log Number	Control number assigned to the export at the local level, that allows us to track the data back to the facility.
FIRST_MOD_DC	First Modified Date i.e., Export Begin Date (character format)	Begin Date of the date range used by the site to export data to the warehouse. Character field formatted as CCYYMMDD.
IHS_AREA_CD	IHS Area Code	3-character code designation for the 12 IHS Areas. (Used instead of the region code.) Populated by the integration engine.
LAST_MOD_DC	Last Modified Date i.e., Export End Date (character format)	End Date of the date range used by the site to export data to the warehouse. Character field formatted as CCYYMMDD.
REG_CREATE_DC	Registration Record Create Date (character format)	Date that the registration record was created on the local system. Character field formatted as CCYYMMDD.
REG_CREATE_DT	Registration Record Create Date (date format)	Date that the registration record was created on the local system. Date field.
REG_DB_CD	Unique Registration Database ID	Code that identifies the database from which the data originated. Its main function is to be used as an audit trail in the event we need to troubleshoot some data. It is a character ID agreed upon between the sending application and DW.
REG_STATUS_CD	Registration Status Code ('A' = active,' I' = inactive)	Status of a patient registration record and all of its components, i.e. demographic states, charts, aliases, and insurance eligibilities. (Examples why inactive: death of patient, or registration consolidated with another for same patient.)
SRC_BOX_SITE	Name of Exporting Box's Site	Name of Exporting Box's Site.
SRC_FL_NM	Source File Name	Name of the file sent to the IE from the facility.
SRC_SYS_CD	Source System Code	Source System Codes will be unique across all source systems that feed the DW. Therefore, a particular code will also implicitly identify the source system that generated a particular record. (RPMS, DENRUN, CHS638, etc.)
UNIQ_ENCTR_CODE	Unique Encounter ID	Unique encounter (visit) record ID generated by the source system.
UNIQ_REG_CODE	Unique Registration Code	Unique registration record ID generated by the source system. (It is unique by registration record, not necessarily by patient if a given patient has more than one registration record at the same facility or different facilities.)

3.00 Patient Demographics

Data Elements sorted by Category

BENEF_CLASS_CD	Beneficiary Classification Code	Classification of the type of patient. See standard code table. (e.g., Indian or Alaska Native = '1'; PHS Field Employee = '2'; PHS Commissioned Officer = '3'; etc.)
BIRTH_DC	Date of Birth (character format)	Patient's Date of Birth. Character field formatted as CCYYMMDD.
BIRTH_DT	Date of Birth (date format)	Patient's Date of Birth. Date field.
BLOOD_QUANTUM_CD	Blood Quantum Code	Code to designate whether or not the patient is an American Indian/Alaska Native and, if so, their quantum. See standard code table. (e.g., Full = '1'; Greater than or equal to 1/2 but less than full = '2'; Non-Indian = '5'; etc.)
CITY_NM	City	City or town portion of this patient's mailing address.
COMM_RES_CD	Community of Residence Code	Code for the State/County/Community of Residence of the patient. See standard code table.
COMM_RES_START_DC	Date Moved To Community (character format)	Date when the patient first moved to this community of residence. Character field formatted as CCYYMMDD.
COMM_RES_START_DT	Date Moved To Community (date format)	This is the date when the patient first moved to this community of residence. Date field.
CONSULT_QTY	Number of Consults	Number of consults during an inpatient stay.
DEATH_DC	Date of Death (character format)	Patient's Date of Death. Character field formatted as CCYYMMDD.
DEATH_DT	Date of Death (date format)	Patient's Date of Death. Date field.
DEATH_ICD9_DX_CD	Cause of Death	ICD-9 code for cause of death. Nationally recognized standard code set. Preferred format is to include the dot.
FATHER_FIRST_NM	Father's First Name	Father's First Name.
FATHER_LAST_NM	Father's Last Name	Father's Last Name.
FATHER_MID_NM	Father's Middle Name	Father's Middle Name.
FIRST_NM	First Name	First name of the patient; could also be an alias.
FULL_NM	Full Name	Patient's name prior to parsing into first, middle, last, etc. The format is specific to the local system.
GENDER_CD	Gender	Sex of Patient as provided by the patient's registration information.
LAST_NM	Last Name	Last name of the patient; could also be an alias.
LOCAL_VERIF_CD	Local SSN Verification Code	Field used by local facilities if they use the SSA information sent them to update their local databases. If they update their records to a "verified" code, they can use this field to note it.
MAIL_ADDR_1	Mailing Address Street 1	First line of the street address portion of this patient's mailing address, P.O. box, or rural route address of the patient.
MAIL_ADDR_2	Mailing Address Street 2	Second line of the street address portion of this patient's mailing address, P.O. box, or rural route address of the patient.
MID_NM	Middle Name	Middle name of the patient; could also be an alias.
MOM_MAIDEN_FIRST	Mother's Maiden First Name	Mother's First Name.
MOM_MAIDEN_LAST	Mother's Maiden Last Name	Mother's Maiden Last Name.
MOM_MAIDEN_MID	Mother's Maiden Middle Name	Mother's Middle Name.
NM_SUFX	Name Suffix	Name suffix, such as Sr., Jr., III, etc.
NM_TITLE	Title	Title of the patient, such as Mr., Ms., Mrs., Miss, etc.

Data Elements sorted by Category

SSN	Social Security Number	Social Security Number of the patient.
STATE_ABBR_CD	State Code	Two digit state code for this patient's mailing address.
SVC_ELIG_CD	Service Eligibility Code	Code that specifies the types of services for which this patient was eligible. See standard code table. (e.g., CHS & Direct = 'C', Ineligible = 'I', Direct only = 'D', Pending Verification = 'P'. Note: Native Americans cannot be coded "ineligible'.)
TRIBE_CD	Tribe Code	Code for the Indian tribe of the patient. See standard code table. (e.g., Aluet = '002', Eskimo = '003', Apache = '004'.)
VET_FG	Veteran Flag	Identifies a person who has previously served in the US Military. Veterans generally receive special veteran's assistance for medical bills. (Y/N). Note: This flag indicates if the patient is a veteran. It is NOT intended to identify all patients who are eligible for veteran's benefits.
ZIP_CODE	Zip Code	Zip code for this patient's mailing address. In RPMS exports, this field will also contain the 4 char zip code extension; NPIRS and the Data Warehouse separate and then correctly populate zip code and zip code extension (first 5 and last 4 chars of data sent). All other exports are expected to send the 4-char zip code extension separately, if available.
ZIP_CODE_EXTN	Zip Code Extension	The additional 4-characters that follow the 5-character zip code, if available, for this patient's mailing address. In RPMS exports, the zip code extension is contained in the zip code field; NPIRS and the data warehouse separate and then correctly populate zip code and zip code extension (first 5 and last 4 chars of data sent). All other exports are expected to send the 4-char zip code extension separately, if available.

4.00 3rd Party Eligibility

CVG_TP_CODE	Coverage Type Code	Type of third party coverage for which the patient is eligible.
ELIG_END_DC	Eligibility End Date (character format)	For Medicaid and Medicare, the eligibility end date; for private insurance, the expiration date. Character field formatted as CCYYMMDD.
ELIG_END_DT	Eligibility End Date (date format)	For Medicaid and Medicare this will be the eligibility end date; for private insurance this will be the expiration date. Date field.
ELIG_START_DC	Eligibility Start Date (character format)	Date that eligibility for the specific type of coverage begins. For Medicaid and Medicare, the eligibility date; for private insurance, the effective date. Character field formatted as CCYYMMDD.
ELIG_START_DT	Eligibility Start Date (date format)	Date that eligibility for the specific type of coverage begins. For Medicaid and Medicare this will be the eligibility date; for private insurance this will be the effective date. Date field.
INSUR_CAT_CD	Insurance Category Code	Type of Eligibility ('MCD' = Medicaid, 'MCR' = Medicare, 'RRE' = Railroad Retirement, 'PVT' = Private Insurance).
INSURER_EIN	Insurer EIN	Insurer's Employer Identification Number.
INSURER_NM	Insurer Name	Usually the name of the insurance company.
NBR_PREFX_SUFX	Policy Prefix/Suffix	Policy suffix for Medicare, or prefix for Railroad Retirement.
PLAN_NM	Plan Name	Plan Name for Medicaid Coverage. Applicable Only for Medicaid.
PLCY_NBR	Policy Number	Policy Number.

PLCYHLDR_FIRST_NM	Policy Holder's First Name	First name of the insurance policy holder.
PLCYHLDR_FULL_NM	Policy Holder's Full Name	Policy holder's name prior to parsing into first, middle, last, etc.
PLCYHLDR_LAST_NM	Policy Holder's Last Name	Last name of the Insurance Policy holder.
PLCYHLDR_MID_NM	Policy Holder's Middle Name	Middle name of the insurance policy holder.
RELAT_TO_INSRD	Relationship to Insured	Patient's relationship to the insured - applicable only for Medicaid and Private insurance. This will be the applicable code for "relationship to insured" used by UB-92, a nationally recognized standard for electronic claims submission.
STATE_CD	Eligibility State Code	State where a patient is eligible for Medicaid.

5.00 Encounter Demographics

ADMISS_SVC_CD	Admission Service	Hospital service to which the patient was admitted. See standard code table. (e.g., Dental = '1', ENT = '2'.)
ADMISS_TP_CD	Admission Type	"Type" of admission. See standard code table. (e.g., Direct = '1', Transfer IHS = '3'.)
CLINIC_CD	Clinic Code	The clinic in which this visit occurred. See standard code table. (e.g., General = '1'; Internal Medicine = '13'; Nephrology = '49'; etc.)
DAY_OF_WEEK_CD	Day of Week	Day Of Week the encounter/admission occurred. ('0' = Sunday, '1' = Monday, etc.)
DISCH_DC	Discharge Date (character format)	Inpatient: date patient discharged. Outpatient: null. Character field formatted as CCYYMMDD.
DISCH_DT	Discharge Date (date format)	Inpatient: date patient discharged. Outpatient: null. Date field.
DISCH_SVC_CD	Discharge Service Code	Code for the service from which the patient was discharged. See standard code table. (e.g., Dental = '1', ENT = '2'.)
DISCH_TP_CD	Discharge Type Code	Identifies how a patient was discharged from an inpatient (i.e., hospital) visit.
ER_DISP_CD	Disposition On ER Visits	The disposition code, if this is an ER visit. See standard code table.
LENGTH_OF_STAY	Length of Stay	Number of days the patient was in the hospital.
LOE_FAC_CD	Location of Encounter	Facility code for the location where the visit took place.
SVC_ADMISS_DC	Service / Admission Date (character format)	Outpatient: date of service. Inpatient: admission date. Character field formatted as CCYYMMDD.
SVC_ADMISS_DT	Service / Admission Date (date format)	Outpatient: date of service. Inpatient: admission date. Date field.
SVC_CAT_CD	Service Category Code	Service category for this encounter. See standard code table. (e.g., Hospital = 'H', Chart Review. = 'C'.)
SVC_LEVEL_CD	Service Level Code	Code that specifies the Level of Service for this encounter. See standard code table. (e.g., Brief = 'B', Limited = 'L', Comprehensive = 'C'.)
SVC_TP_CD	Service Type Code	A code that specifies the "Type of Visit" for this encounter. See standard code table. (e.g., IHS = '.I', Contract = 'C', Tribe-Non 638/Non-Compact = 'T', Other = 'O'. "Other" is used for anything usually done outside of IHS. For example, if a visit is recorded for a surgical procedure done historically or at a facility outside of IHS, then "Other" is used.
TIME_OF_DAY	Time of Day	Time of day the encounter/admission occurred.
TRANSFER_FAC_CD	Transfer Facility Code	Code that is used to specify the facility to which the patient was transferred. The facility code is from a standard code table.

Data Elements sorted by Category

7.00 Provider

ATND_PHYS_AFFL_CD	Attending Physician Affiliation Code	Affiliation of the attending physician. See standard code table. (e.g., IHS = '1'; Contract = '2'; Tribal = '3'; etc.)
ATND_PHYS_DISC_CD	Attending Physician Discipline Code	Discipline of the attending physician. See standard code table. (e.g., Physician = '0', Physician Assistant = '11'.)
MIDWIFERY_FG	Midwifery Flag	A flag to indicate if the provider is a midwife.
PHYS_LOCL_CODE	Attending Physician Local Code	The code used at the site to identify the attending physician. Usually, but not always the physician's initials.
PROV_AFFL_CD	Provider Affiliation Code	The affiliation of the provider. See standard code table. (e.g., IHS = '1'; Contract = '2'; Tribal = '3'; etc.)
PROV_DISC_CD	Provider Discipline Code	The discipline of the provider. See standard code table. (e.g., Physician = '0', Physician Assistant = '11'.)
PROV_LOCAL_TEXT	Provider Local Code	Code used at the site to identify the provider. Usually, but not always the provider's initials.
PROV_X12_CLASS_CD	Provider Class X12 Code	The HIPAA "provider classification" code, a more specific service or occupation related to the Provider Type. For example, the Classification for Allopathic & Osteopathic Physicians is based upon the General Specialty Certificates as issued by the appropriate national boards.
PROV_X12_SPEC_CD	Provider Spec X12 Code	HIPAA "provider specialization" code, a more specialized area of the Classification in which a provider chooses to practice or make services available. For example, the Area of Specialization for provider type Allopathic & Osteopathic Physicians is based upon the Subspecialty Certificates as issued by the appropriate national boards.
PROV_X12_TP_CD	Provider Type X12 Code	The HIPAA "provider type" code, a major grouping of service(s) or occupation(s) of health care providers. For example: Allopathic & Osteopathic Physicians, Dental Providers, Hospitals, etc. See standard code table.

8.00 Patient History

HTN_EVER_DOC_FG	HTN Ever Documented Flag	Has this patient ever had Hypertension documented as a "Purpose of a Visit?" (Y/N)
HTN_LAST_DOC_DC	HTN Last Documented (character format)	Date Hypertension (HTN) was last documented as a Purpose Of Visit (POV), if ever. Character field formatted as CCYYMMDD.
HTN_LAST_DOC_DT	HTN Last Documented (date format)	Date Hypertension (HTN) last documented as a Purpose Of Visit (POV). Date field.
LMP_DC	Last Menstrual Period (character format)	Last known menstrual period on file. (Note: this may not be current. Check against date noted.) Format: CCYYMMDD
LMP_DT	Last Menstrual Period (date format)	Last known menstrual period on file. (Note: this may not be current. Check against date noted.) Date field.
LMP_NOTED_DC	LMP Noted (character format)	Date the last menstrual period on file was noted. Format: CCYYMMDD
LMP_NOTED_DT	LMP Noted (date format)	Date the last menstrual period on file was noted. Date field.

9.00 Measurements

CLIN_MEAS_CD	Clinical Measure Code	Code describing the type of measurement that is being captured. ('1' = Height, '2' = Weight, '4' = Blood Pressure.)

Data Elements sorted by Category

CM_RSLT_VALUE	Clinical Measure Result Value	This field will be used for Blood Pressure, Height, & Weight. BP to be reported in ###/### format, height to be output in inches in ##.# format, weight in pounds in ###.# format.

10.00 Exams

EXAM_IHS_CD	Exam IHS Code	Exam that was performed on the patient during this encounter. See standard code table. (e.g., General exam = '1', Ear exam = '2', Diabetic eye exam = '3'.)

11.00 Procedures

CPT_CD	CPT Code	CPT code for the specified procedure. Nationally recognized standard code set. Replaced by HCPCS_CD. (see whitepaper)
CPT_QTY	CPT Quantity	Number of CPT codes.
EVAL_MGT_CPT_CD	Evaluation and Management CPT Code	CPT code from evaluation and management field of visit file. Nationally recognized standard code set.
HCPCS_CD	HCPCS / CPT Code	HCPCS (including CPT) code for the specified procedure. Nationally recognized standard code set.
ICD9_PROC_CD	ICD9 Procedure Code	ICD-9 procedure code for the specified procedure. Nationally recognized standard code set. Preferred format is to include the dot.
INFECT_FG	Infection Flag	Was this procedure related to an infection. (Y/N)
PROC_DC	Procedure Date (character format)	Date the procedure took place. (CCYYMMDD format.)
PROC_DT	Procedure Date (date format)	Date the procedure took place. Date field.

12.00 Labs

FEC_OCLT_BLOOD_FG	Fecal Occult Blood Lab Flag	Was a fecal occult blood test performed during this encounter? (Y/N)
GLUCOSE_VAL	Glucose Value	Result value for a glucose test obtained during this encounter.
HDL_CHOL_FG	HDL Cholesterol Test Flag	Was an HDL cholesterol test performed during this encounter? (Y/N)
HDL_CHOL_VAL	HDL Cholesterol Value	Result value for an HDL cholesterol test obtained during this encounter.
HGBA1C_VAL	HGB A1C Value	This HgbA1C lab test will be stored in the LAB_TEST table with LOINC code 4548-4.
LAB_TEST_NM	Lab Test Name	Lab test name as stored in the local system.
LAB_TEST_QTY	Number of Lab Tests Done	Total number of lab tests that were performed for this visit.
LDL_CHOL_FG	LDL Cholesterol Test Flag	Was an LDL cholesterol test performed during this encounter? (Y/N)
LDL_CHOL_VAL	LDL Cholesterol Value	Result value for an LDL cholesterol test obtained during this encounter.
LOINC_CD	LOINC Code	Logical Observation Identifiers Names and Codes (LOINC). Nationally recognized standard code set to identify the lab test.
MICROALBUM_FG	Microalbuminuria Flag	Was an Microalbuminuria test performed during this encounter (Y/N)?
MICROALBUM_VAL	Microalbuminuria Value	Value of the Microalbuminuria test.
PAP_FG	Pap Lab Test Flag	Was a Pap test performed during this encounter? (Y/N)
PSA_FG	PSA Lab Test Flag	Was a Prostate Specific Antigen test performed during this encounter? (Y/N)

RANGE_LOWER_LMT	Range Lower Limit	Lower limit for the normal reference range of the associated lab test.
RANGE_UPPER_LMT	Range Upper Limit	Upper limit for the normal reference range of the associated lab test.
TRIGLYC_FG	Tryglyceride Test Flag	Was a triglyceride test performed during this encounter? (Y/N)
TRIGLYC_VAL	Triglyceride Value	Result value for a triglyceride test obtained during this encounter
UNIT_OF_MEAS	Unit of Measure	Unit of measure for the lab result.
URIN_PROTN_FG	Urine Protein Test Flag	Was a urine protein test performed during this encounter? (Y/N)
URIN_PROTN_VAL	Urine Protein Value	Result value for a urine protein test obtained during this encounter.

13.00 Diagnoses

DX_CAUSE_CD	Cause of Diagnosis	Code for the "cause" of this specified diagnosis. See standard code table. (e.g., Hospital acquired = '1'; Alcohol-related = '2'; Battered-child = '3'; etc.)
DX_SEQ_NBR	Diagnosis Sequence Number	Sequence number of the diagnosis for which the CPT procedure was performed, if applicable. It is used to link this PROCEDURE record with the appropriate DX record.
ICD9_DX_CD	Diagnosis Code (Purpose of Visit)	Purpose of Visit ICD-9 diagnostic code. The diagnosis whose Diagnosis Sequence Number = '1' is considered the primary diagnosis. Nationally recognized standard code set. Preferred format is to include the dot.
ICD9_EXT_INJ_CD	Cause of Injury	ICD-9 E code for the cause of the injury. (Only used if diagnosis code is between 800 and 999.9, meaning injury.) Nationally recognized standard code set. Preferred format is to include the dot.
INJ_PLACE_CD	Place of Injury	Code for the place of injury. (Only used if ICD-9 diagnosis code is between 800 and 999.9, signifying an injury.) See standard code table. (e.g., Home-Inside = 'A'; Home-Outside = 'B'; Farm = 'C'; etc.)

14.00 Health Factors

HLTH_FACTR_NM	Health Factor Name	Name of Health Factor. (e.g., 'previous smoker'.)
HLTH_FACTR_CAT	Health Factor Category	Health factor category. (e.g., 'Tobacco'.)
HLTH_FACTR_CAT_CO	Health Factory Category Code	Health factor category code.
HLTH_FACTR_CD	Health Factor Code	Health Factor code.

15.00 Immunizations

HL7_IMMUN_CD	HL7 Immunization Code	Proprietary subset of HL7 used by IHS beginning with version 7.0 of the RPMS Immunization Package. This was replaced in version 8.0 with the complete HL7 CVX code list.
HL7_IMMUN_CVX_CD	Immunization Formulation Code	HL7's CVX code for the vaccine formulation. See standard code table. (e.g., DPT = '1', Measles and rubella virus vaccine = '4'.)
HL7_IMMUN_MVX_CD	Immunization Manufacturer Code	HL7's MVX code for the vaccine's manufacturer See standard code table. (e.g., Abbott Laboratories = 'AB', Aventis Behring L.L.C. = 'AVB'.)
IHS_IMMUN_CD	IHS Immunization Code	Proprietary code for immunizations used by IHS prior to version 7.0 of the RPMS Immunization Package.

IMM_DOSE_NBR_CD	Immunization Dose Number Code	The dose in an immunization series that was provided on this encounter. (Some immunizations require multiple doses over a period of time. Not necessarily a number.)

16.00 Skin Tests

SKIN_TEST_CD	Skin Test Code	Code for a skin test performed during this visit. See standard code table. (e.g., '20' = Tine, '21' = ppd, '22' = Schick, '23' = Cocci)
SKIN_TEST_READING	Skin Test Reading	Numeric measurement in mm of a skin test measured during this visit.
SKIN_TEST_RSLT_CD	Skin Test Result Code	Code for a skin test result, reading performed during this visit. See standard code table. (e.g., 'P' = Positive; 'N' = Negative; 'D' = Doubtful; 'O' = No Take.)

17.00 Medications

ACE_INHIB_FILL_FG	Ace Inhibitor Fill Flag	Was an ACE INHIBITOR prescribed and/or filled during this encounter (Y/N)?
MED_NDC_CODE	Medication NDC Code	National Drug Code (NDC) for this medication as stored in the local system. Nationally recognized standard code set
MED_NM	Medication Name	Name of the medication as stored in the local system.
MED_QTY	Medication Quantity	Quantity of medicine dispensed (e.g., number of pills, milliliters of a liquid preparation, grams of a topical cream, etc.). Entry is a number, units (# of pills, mls, mgs, etc.) are implicit in the NDC code. (Formatted as a number up to 9999999.999.)
VA_DRUG_CLASS_CD	VA Drug Class Code	Code representing the VA Drug Class. This code is assigned by the local system. See standard code table. (e.g., Penicillin G-related penicillins = 'AM051', Opioid antagonist analgesics = 'CN102'.)

18.00 Patient Education

DM_NUTR_EDUC_FG	DM Nutrition Education Flag	Was Diabetes Mellitus education given to the patient? (Y/N)
EDUC_CD	Education Code	Code that specifies the topic of education provided during this encounter. See standard code table. (e.g., Child Health Newborn Parenting = 'CHN-PA', Diabetes Mellitus Exercise = 'DM-EX', etc.)
EDUC_MINS	Length of Education	Length, in minutes, of the patient education provided for this specified topic.
EDUC_UNDERSTAND_C	Education Understanding	Education - patient's level of understanding ('1' For Poor; '2' For Fair; '3' For Good; '4' For Group-No Assessment; '5' For Refused.)

19.00 Dental

ADA_CD	ADA Code	American Dental Association code that designates the type of dental service provided during this encounter. Nationally recognized standard code set.
ADA_FEE_AMT	ADA Code Fee	Fee for this ADA Code rounded to the nearest dollar.
ADA_UNITS	ADA Units	Number of the services identified by the ADA code that were delivered (e.g., if the ADA code is for tooth extraction and the ADA units are '3', that means three teeth were extracted).
COMMRCL_INSUR_FG	Commercial Insurance Flag	Received via contract dental (DENSTAT).
DEN_COST_AMT	Dental Cost	Dental Total Cost rounded to the nearest dollar.

DEN_DELIVERY_CD	Dental Delivery Code	Used exclusively by dental to indicate if the visit was Direct or Contract. ('D' or 'K')
DEN_PAT_TP_CD	Dental Patient Type Code	Used exclusively by dental to determine is a patient is indian or non-indian. Values are 'I', 'P', 'O', 'S', 'N', 'C'.
OPSITE_CD	Dental Operative Site	Code used to identify the tooth, range of teeth, or other location for which the ADA procedure was performed. (e.g., Upper right 2nd permanent molar = '2', Upper right 2nd primary molar = 'A'.)
OPSITE_SURF_NBR	Dental Tooth Surface	Code used to identify the surface of the tooth for which the ADA procedure was performed.
RPT_DENTIST_SSN	Dentist's SSN	SSN for the dental provider. (format 999999999, no dashes.)

20.00 PHN

PHN_ACT_CD	PHN Activity Code	Activity Code used for reporting PHN visits. ('01' = Home, '02' = Other, '03' = Patient not found.)
PHN_ACTIVITY_MINS	PHN Activity Minutes	Total number of minutes to complete the activity.
PHN_INTERV_LVL_CD	PHN Intervention Level ('P' = primary, 'S' = secondary, 'T' = tertiary)	Level of Intervention code used of Public Health Nursing reporting.
PHN_TRAVEL_MINS	PHN Travel Minutes	Travel Time recorded in minutes.

21.00 CHS

AUTH_FAC_CD	Authorizing Facility	Facility that authorized the vendor to provide services to the patient. See standard code table.
AUTH_NBR	Authorization Number	Number assigned to the specific authorization for contract services (authorizes the vendor to provide services to the patient).
CHS_COST_AMT	CHS Cost	For CHS visits, total cost information. Preferred format is 999999.99.
ENCTR_QTY	Encounter Quantity	What CHS considers workload units. This could be number of orders filled, number of devices, number of eyeglasses, number of prescriptions, etc., depending upon the Object Class Code.
PO_NBR	Purchase Order Number	Number assigned to the specific purchase order for contract services.

100.00 Internal Record Designators

ACK_DT	Data Received and Acknowledge Date (date format)	The date that the warehouse received data and sent acknowledgement to originator. Date field.
CURR_ENCTR_SS_FG	Current Encounter Flag	The encounter that contains the most current information.
DEL_REC_FG	Delete Record Flag	This flag will be set by the DW to Y if the latest snapshot of this encounter was flagged as having been deleted from the local system. This flag will be set as described for all snapshots of the specified encounter, not just the encounter whose "Encounter Delete Flag" was set to 'Y' by the local system.
ENC_ADD_QTY	Encounter Records Added	The number of encounter records that were inserted into the warehouse database, i.e. number of new visits.
ENC_CHANGE_QTY	Encounter Records Changed	The number of encounter records that were updated in the warehouse database, i.e. number of changed visits.
ENC_DEL_QTY	Encounter Records Deleted	The number of encounter records that were flagged as deleted in the warehouse database, i.e. number of deleted visits.
ENC_ERROR_QTY	Encounter Records Errors	The number of encounter records that were not processed by the warehouse, i.e. number of rejected visit records.

Data Elements sorted by Category

ENCTR_SKIPPED_QTY	PCC Visits Skipped (RPMS systems only)	Total number of PCC visits skipped (not exported).
ENCTR_SUPERCD_DT	Encounter Superceded Date (date format)	This is the date when more current information is received and this record is "replaced." Date field.
ENCTRSS_ID	Encounter Snapshot ID	This ID is generated internally by the DW and is used to uniquely identify the encounter.
ERROR_CATEGORY_CD	Error Category Code	Category assigned to the record to designate if processed or in error.
ERROR_DESCRIPTION	Error Description	Used to track errors found during ETL process. This is a brief description of the error.
EXPORT_ID	Export ID	Each export file that is received by the DW will be assigned a unique export ID number. This will allow us to track each record back to the "raw data file" if necessary. It also allows us to track certain information specific to each export such as number of records, date received, etc.
FIELD_CHANGE_CODE	Any Field in this Subset Modified Since Last Exported?	Field used by the source system to indicate to the NDW how to process this subset of records.
FIELD_NAME	Field Name	Used to track errors found during ETL process. This is the name of the field that was in error.
IE_FL_EXPORT_DC	IE File Export Date (character format)	The date the file is processed by the integration engine. Character field formatted as CCYYMMDD.
IE_FL_NM	IE File Name	The name of the file the integration engine sends to the data warehouse.
IE_REC_QTY	IE Record Count	Total number of non-header records in the file sent from integration engine to the data warehouse.
LOAD_TARGET_DT	Data Loaded into DW Date (date format)	This the the date that the data was processed and loaded into the warehouse's target tables. Date field.
MSG_CTRL_NBR	Message Control Number	A control number will be assigned to each message by the IE, which will be written to each record in the ASCII file so the DW will know which records belong to which registration / encounter.
NEW_VALUE	New Value	Used to track errors found during ETL process. If the content of the field was transformed, this is the what the data was changed to.
OLD_VALUE	Old Value	Used to track errors found during ETL process. If the content of the field was transformed, this is the original value of the data.
P000_QTY	Number of P000 Records	Number of records in the export designated as P000; should be the number of visit records.
PCC_ENCTR_QTY	Number of PCC Visits	The total number of pcc visits that are contained in this export.
PHDR_QTY	Number of PHDR Records	Number of records in the export designated as PHDR.
PROCESS_CD	Process Code	Used to track and in some cases control the progress through the ETL processes associated with a set of DW input records. Obsolete, status of file can be determined via admin.export_info columns error_category_cd and process_status_notes.
R000_QTY	Number of R000 Records	Number of records in the export designated as R000; should be the number of registration records.
REC_CD	Record Code	A code of up to four characters that identifies the record format that defines that particular record. This field is populated by the integration engine.

Data Elements sorted by Category

REC_TOTALS_MATCH_	Record Totals Match Flag	The warehouse will count the number of records received, etc., then match the quantities to the counts transmitted in the export. The quantities should match. If not, there is an problem with the transmission and the customer is notified. (Y/N)
REG_ADD_QTY	Registration Records Added	The number of registration records that were inserted into the warehouse database, i.e. number of new patients.
REG_CHANGE_QTY	Registration Records Changed	The number of registration records that were updated in the warehouse database, i.e. number of changed patients.
REG_DEL_QTY	Registration Records Deleted	The number of registration records that were flagged as deleted in the warehouse database, i.e. number of deleted patients.
REG_ERROR_QTY	Registration Records Errors	The number of registration records that were not processed by the warehouse, i.e. number of rejected patient records.
ROW_CREATE_TS	Row Creation Date and Time stamp	Date/Time that this row was created in the data warehouse.
ROW_CREATOR	Row Creator	Person or process that created the row in the data warehouse.
SEQ_NBR	Sequence Number	For the first occurrence, the sequence number is 1; for the second occurrence, the sequence number is 2, and so on.
SKIP_DEMO_PAT_QTY	Skipped Demo Patients (RPMS systems only)	Number of PCC visits not exported because the patient's name was 'DEMO, PATIENT'.
SKIP_ERROR_QTY	PCC Visit Errors (RPMS systems only)	Number of PCC visits skipped (not exported) due to error.
SRC_FL_EXPORT_DC	Source File Export Date (character format)	Date the export was run at the facility. Character field formatted as CCYYMMDD.
SRC_FL_REC_QTY	Source File Record Quantity	Total number of records contained in the source file, i.e., the file the IE receives from the facility. This should be the number of HL7 messages.
TOTAL_REC_QTY	Total Number of Records	This is the total number of export records received by the data warehouse.

100.10 Defered to DW2

FIRST_DOC_DT	Medical Condition First Documented Date (date format)	The date the condition was first documented. Date field.
FIRST_OCCUR_DT	Medical Condition First Occurred Date (date format)	The date the condition began. Date field.
REMOVED_DT	Medical Condition Removed Date (date format)	Date field.
LAST_DOC_DT	Medical Condition Last Documented Date (date format)	The date the condition was last documented. Date field.
LAST_OCCUR_DT	Medical Condition Last Occurred Date (date format)	The date the condition ended. Date field.
MED_COND_CAT_CD	Medical Condition Category Code	Clinical in nature; related to the patient rather than the encounter.
MED_COND_CD	Medical Condition Code	A code representing a medical condition (e.g., being HIV positive) that characterizes a particular patient for a limited period of time.

100.20 SSA verification

SSA_FIRST_NM	SSA First Name	First name used to verify the patient's SSN with the SSA.
SSA_MID_NM	SSA Middle Name	Middle name used to verify the patient's SSN with the SSA.
SSA_VERIF_CD	SSA Verification Code	This is the code assigned to the patient by the SSA as a result of their verification process.

Data Elements sorted by Category

SSA_VERIF_L_NM	SSA Verification Last Name	The SSA has specific requirements for how the last name must be formatted, (for example, no hyphens or dashes in the name,) so we will use this field to store this information so we only have to derive it one time.
SSN_PSEUDO	Social Security Number Pseudo-code	Field used by the load process to determine if the SSN is actually a pseudo-ssn assigned by the facility.
SUSP_SSN_FG	Suspect SSN Number Flag	This flag is set using the algorithm currently used by NPIRS to determine if an SSN is invalid and therefore should be excluded from the export to SSA. This way we only have to check the SSN one time.